Kansas Department on Aging

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	EIED
		B087117	B. WING		07/1	6/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CATHOLIC	CHADITIES ADMIT DA	5920 W CE	ENTRAL ST			
CATHOLIC	C CHARITIES ADULT DA	WICHITA,	KS 67212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS		S 000			
		s represent the findings of a adult day care facility on 7/16/14.				
S2175 SS=E	26-43-204 (d) Health	Care Services	S2175			
	contain a description to be provided and th	ervice agreement shall of the health care services e name of the licensed the implementation and n.				
	This REQUIREMENT by: KAR 26-43-204(d)	is not met as evidenced				
	The sample included record review and into of 3 residents sample	plementation and				
	Findings included:					
	admission date of 1/8 dementia. The functi 12/10/13 indicated the supervision with dres walking, and eating; wanagement of medi assistance with manaexperienced impaired decision making, and risk for falls. The NS.	sing, toileting, transferring, vas unable to perform cations; required physical gement of treatments;				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B087117	B. WING		07/1	6/2014
	ROVIDER OR SUPPLIER	5920 W CE		TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S2175	at meals, and assista and toileting. The NS licensed nurse #F as responsible for the nurse respo	prescribed, monthly ressure and weight, cal treatments, cut up meat nce as needed with walking SA contained the name of the registered nurse ursing plan.  esident #130 revealed an s/13 and a diagnosis of brain kia. The functional capacity indicated the resident istance with dressing, supervision with transferring; anagement of medications rienced impaired short-term aking, and memory recall; lls. The NSA dated 2/17/14 eservices medication nsed nurse as prescribed, follood pressure and weight, cal treatments, and did with transferring and ontained the name of the registered nurse ursing plan.  14, the operator confirmed revorked at the facility and sponsible for the supervision of the plan.	S2175			
S2233 SS=F	26-43-205 (g) (3) Ove	er the counter medication	S2233			

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  \$20 W CENTRAL ST WICHTA, KS \$7212    D	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
CATHOLIC CHARITIES ADULT DAY SERVICES  S820 W CENTRAL ST WICHTAL, KS 67212    O(4) D   PREPIX   SUMMARY STATEMENT OF DEFICIENCIES   D   PREPIX   CROSS-REPERRACED TO THE APPROPRIATE   OFFICIENCY MUST BE PRECEDED BY FULL   TAG   CROSS-REPERRACED TO THE APPROPRIATE   OFFICIENCY   OATE			B087117		B. WING		0	7/16/2014
CATHOLIC CHARTIES ADULT DAY SERVICES   WICHITA, KS 67212	NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  S2233  Continued From page 2  (g) (3) A licensed nurse or medication only in its original, unbroken manufacturer's package. A licensed pharmacist or ilcensed nurse shall place the full name of the resident on both the original manufacturer's medication on the medication on the original place the full name of the resident on both the original manufacturer's medication on the package. If the original manufacturer's package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer's medication package and the medication container.  This REQUIREMENT is not met as evidenced by:  KAR 26-43-205(g)(3)  The facility reported a census of 12 residents. The sample included 3 residents sampled and any other residents receiving over-the counter medications, the licensed nurse falled to ensure residents receiving over-the counter medications package that the licensed nurse labeled with the full name of the resident.  Findings included:  - Record review for resident #120 revealed an admission date of 9/18/13 and a diagnosis of dementia. The functional capacity screen (FCS) dated 9/16/13 indicated the resident was mable	CATHOLIC	CHARITIES ADULT DA	Y SERVICES					
(g) (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer 's package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer 's package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer's medication package and the medication container.  This REQUIREMENT is not met as evidenced by: KAR 26-43-205(g)(3)  The facility reported a census of 12 residents. The sample included 3 residents. Based on record review, interview, and observation for 2 (#120 and #130) of 3 residents sampled and any other residents receiving over-the counter medications, the licensed nurse failed to ensure residents received over-the-counter medications from the original over-the-counter medication package that the licensed nurse labeled with the full name of the resident #120 revealed an admission date of 9/18/13 and a diagnosis of dementia. The functional capacity screen (FCS) dated 9/16/13 indicated the resident was unable	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY F	FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	COMPLETE
treatments. The negotiated service agreement (NSA) dated 9/16/13 contained documentation that the licensed nurse administered medications	S2233	(g) (3) A licensed nursaccept over-the-counoriginal, unbroken malicensed pharmacist of the full name of the rethe original manufactor over-the-counter medication in a contabe removed from the licensed pharmacist of place the full name of original manufacturer the medication contains.  This REQUIREMENT by: KAR 26-43-205(g)(3)  The facility reported at The sample included record review, intervied (#120 and #130) of 3 other residents received over the original over package that the licental residents received over package that the licental residents included:  Record review for readmission date of 9/1 dementia. The function dated 9/16/13 indicate to perform management treatments. The negon (NSA) dated 9/16/13	se or medication aide ter medication only in unufacturer 's package or licensed nurse shall esident on the package urer 's package of an lication contains a iner, bottle, or tube thoriginal package, the or a licensed nurse shall the resident on bother is medication packagener.  The census of 12 residents are sidents. Based on the residents ampled and ring over-the counter medicated nurse failed to erer-the-counter medicated nurse labeled with ent.  The sident #120 revealed 8/13 and a diagnosis on all capacity screen (resident was une of the resident wa	its e. A I place e. If at can all the ge and aced ats. n or 2 nd any ations on th the d an of (FCS) nable d nent tion	S2233			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B087117		B. WING		07/1	6/2014
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CATHOLIC	CHARITIES ADULT DAY	/ SERVICES	5920 W CE	NTRAL ST			
CATHOLIC	CHARITIES ADOLT DA	JERVICES	WICHITA, K	(S 67212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFE DEFICIENCY)	) BE	(X5) COMPLETE DATE
S2233	Continued From page	: 3		S2233			
S2233	orders signed by a mover-the counter med basis. Review of doc administration to resident received ace one tablet on 2/10/14, on 1/23/14 for limping Resident received 1 tamilligrams on 1/24/14  - Record review for readmission date of 3/6 damage due to hypox indicated the resident management of media. The NSA dated 2/17/15 that the licensed nurs as prescribed. The reorders signed by a mover-the counter med basis. Review of docu administration to resident received ace 2 tablets on 5/28/14 for At 1:45 p.m. on 7/14/15 confirmed residents # orders for over-the counter med basis. Review of docu administration to resident received ace 2 tablets on 5/28/14 for At 1:45 p.m. on 7/14/15 confirmed residents # orders for over-the counter med basis. Review of docu administration to resident received ace 2 tablets on 5/28/14 for At 1:45 p.m. on 7/14/15 confirmed residents # orders for over-the counter med basis. Review of docu administration to resident received ace 2 tablets on 5/28/14 for At 1:45 p.m. on 7/14/15 confirmed residents # orders for over-the counter and a package of antinurse #E removed a tamburse #E remove	ecord contained standinedical care provider for ications on an as needs umentation of medications and 4/3/14 and two tall and difficulty standing ablet of acetaminopher for cold symptoms.  esident #130 revealed a /13 and a diagnosis of italian. The FCS dated 2/1 was unable to perform cations and treatments and treatments are administered medical care provider for ications on an as needs imentation of medications and treatments are cord contained standinedical care provider for ications on an as needs imentation of medications and treatments are complaint of a headar and #130 revealed the taminophen 500 milligror complaint of a headar and #130 had standard and #130 had standard in the intermoved from the total intermedication in a bottle of stomach relief tablet diarrhea tablets. Licenulae of antibiotic cream is contained the full natent. Licensed nurse #E	ed on ams blets	\$2233			
	of an individual reside	ent. Licensed nurse #E stered these medication					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B087117		B. WING		07/	16/2014
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CATHOLIC	C CHARITIES ADULT DA	Y SERVICES	5920 W CE	_			
	OLIMAN DV OT	ATEMENT OF DEFICIE	WICHITA, I		DROWNERIO DI ANI OF CORRECT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDE LSC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S2233	Continued From page	e 4		S2233			
	At 3:45 p.m. on 7/15/ each resident did not medications received labeled by the license full name.	have over-the-co	ounter nurse and				
	For residents #120, #130, and any other residents receiving over-the-counter medications, the licensed nurse failed to ensure residents received over-the-counter medications from the original over-the-counter medication package that the licensed nurse labeled with the full name of the resident.		nedications, sidents s from the backage that				
S2235 SS=F	26-43-205 (h) Medica	ation Storage		S2235			
	(h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer 's recommendations or those of the pharmacy provider and with federal and state laws and regulations.  (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals.  (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication						

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				B. WING				
		B087117		B. WING			07/1	6/2014
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	ΓE, ZIP CODE			
CATHOLIC	C CHARITIES ADULT DA	Y SERVICES		NTRAL ST S 67212				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD IE APPROPR	BE	COMPLETE DATE
S2235	Continued From page	e 5		S2235				
32233	aides.  (3) Any resident who and is unable to provirecommended by the provider may request stored by the facility.  (4) A licensed nurse of administer medications or pharmacy provide expiration.  This REQUIREMENT by: KAR 26-43-205(h)(1)  The facility reported at the sample included record review, intervieresidents, the license the licensed nurse has medications.  - During tour of the factorial factorial forms and the sample included record review intervieresidents, the license the licensed nurse has medications.  - During tour of the factorial factor	self-administers medication ide proper storage as manufacturer or pharmacy that the medication be or medication aide shall not a beyond the manufacturer 'er's recommended date of is not met as evidenced a census of 12 residents. 3 residents. Based on ew, and observation for all d nurse failed to ensure only a daccess to stored access to stored	y	32230				
	anti-diarrhea tablets. removed a tube of an cabinet.  At 2:45 p.m. on 7/14/		d					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		B087117		B. WING		07/16/2014	
	ROVIDER OR SUPPLIER	Y SERVICES	STREET ADD 5920 W CE WICHITA, P		TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	E
S2235	Continued From page the nurse's office and front desk.  At 3:07 p.m. on 7/14/7 desk, when asked wh keys were kept, remo several keys from a d monitor. Went with or and operator used a key open the door to the reserving unlocked the At 3:40 p.m. on 7/15/7 the licensed nurse failicensed nurse had accept to the control of	medication storage at the five the medication storage at the five da key ring holding rawer under the component of the nurse's key from the key ring fourse's office. A key of medication storage of the total confined to ensure only the coess to stored medication.	ront orage g outer office to on the eart. rmed e ations.	S2235			
\$2280 \$\$=F	26-43-102 (d) Staff Q Records  d) The employee records shall contained documentation: (1) Evidence of licens certification, or a certicompletion of a training employee performing specialized education (2) supporting documbackground checks of staff, excluding any state agency, pursuamendments thereto; (3) supporting documnurse aide registry that have a finding of haviexploited a resident in supporting documentation of have a finding of the or exploited any residents.	ords and agency staff the following  ure, registration, ficate of successful age course for each a function that require or training; entation for criminal facility staff and confaff licensed or register ant to K.S.A. 39-970 entation from the Kanfat the individual does age abused, neglected an adult care home; attion that the individual aving abused, neglected and action that the individual action that the individual action that the individual action and action that the individual action and action that the individual action action that the individual action action that the individual action action action that the individual action	es atract ered by and esas not l, or and(4) al does cted,	S2280			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B087117	B. WING		07/16/2014	
NAME OF PI	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, ST	TATE, ZIP CODE		
CATHOLIC	CHARITIES ADULT DA	Y SERVICES	W CENTRAL ST IITA, KS 67212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETE	
S2280	Continued From page	e 7	S2280			
	from the nurse aide re the individual has bee	egistry in each state in which en known to work.				
	This REQUIREMENT by: KAR 26-43-102(d)(2)	is not met as evidenced (3)				
	The sample included record review and into employee files review ensure each employed documentation of a corequested through the documentation from the registry that the indivi	a census of 12 residents. 3 residents. Based on erview for 4 of 4 certified yed, the operator failed to ee file contained supporting riminal background check e department and supporting he Kansas nurse aide idual did not have a finding glected, or exploited a are home.				
	Findings included:					
	assistant (CNA) #A hi 2/11/13, CNA #C hire 10/1/13 revealed the background check the documentation from t registry the CNA did r	e files for certified nursing ired 3/10/14, CNA #B hired d 7/9/13, and CNA #D hired lack of a criminal rough the department and he Kansas nurse aide not have a finding of having r exploited a resident in an				
	human resources obt checks for employees but not through the de telephoned the contra responsible for obtain verification. Contract he/she did obtain the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED				
		B087117		B. WING		07/16/20	014
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CATHOLIC	CHARITIES ADULT DA	Y SERVICES	5920 W CE WICHITA, K				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE C	(X5) COMPLETE DATE
S2280	Continued From page checking the nurse ai CNA on 5/24/14.  For 4 of 4 certified emoperator failed to ensicontained supporting background check reddepartment and supp the Kansas nurse aid did not have a finding neglected, or exploite home.	de registry again for aployee files reviewe ure each employee documentation of a quested through the orting documentatio e registry that the in of having abused,	ed, the file criminal in from dividual	S2280			
\$2330 \$S=F	26-43-104 (d) Disaster Preparedness Educated d) Each administrator disaster and emerger ensuring the performation of new employment to the fact management plan;  (2) education of eadmission to the facility procedures; (3) quarterly review or management plan with and (4) an emergency drill at least annually with drill shall include evacus secure location.	or operator shall er acy preparedness by ance of the following employees at the ti- cility 's emergency each resident upon ity regarding emerge f the facility 's emer h employees and re l, which shall be cor staff and residents.	y g: ime of ency gency esidents; inducted This	S2330			
	This REQUIREMENT by: KAR 26-43-104(d)(3)	is not met as evide	enced				
	The facility reported a	census of 12 reside	ents.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPLE		
	B087117		B. WING		07/1	6/2014
NAME OF PROVIDER OR SUPP	LIER		RESS, CITY, STA	TE, ZIP CODE		
CATHOLIC CHARITIES AL	ULT DAY SERVICES	5920 W CEI WICHITA, K				
PREFIX (EACH D	MARY STATEMENT OF DEFICIE EFICIENCY MUST BE PRECEDEI ORY OR LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
interview for a operator failed the facility's elemployees are emergency process. Findings incluing a failed to condition and the facility's elemployees remanagement residents didentire plan.  For all employees failed to condition emergency management residents didentire plan.	icluded 3 residents. Basell employees and resider of to conduct a quarterly remergency management plant residents to ensure diseparedness.  ded:  n. on 7/14/14, the operator viewed the entire emergency plan 1 time a year. Operator participate in a review rees and residents, the out a quarterly review of the ensure disaster and ensure disaster and ender to ensure disaster and ensure disaster and residents.	nts, the eview of clan with caster and  or stated ency rator stated v of the  perator the facility's ployees	\$2330			